

## PURCHASING POOL CHANGE REPORT FORM

Complete and return to:

840 Helena Avenue  
 Helena, MT 59601  
 Fax: 406-444-3435  
 Phone: 406-444-2040  
 Toll free: 800-332-6148

Employee Name			
Business Name		Insurance Agent Name	
<b>TYPE OF CHANGE</b>			
<input type="checkbox"/> New Employee ESTIMATE QUOTE ONLY (must complete a Premium Assistance Application)			
<input type="checkbox"/> New Employee (must complete a Premium Assistance Application)		Date Employee is Eligible for Health Insurance? (mm/dd/yyyy)	
<input type="checkbox"/> Delete Employee and all dependents as of this date : (mm/dd/yyyy)			
<input type="checkbox"/> Delete Spouse as of this date (mm/dd/yyyy)			
<input type="checkbox"/> Add Spouse as of this date (mm/dd/yyyy) ( provide Name, Date of Birth, and Social Security Number)			
<input type="checkbox"/> Add dependent(s) as of this date (mm/dd/yyyy) (provide name(s), date(s) of birth, and Social Security Number(s))			
<input type="checkbox"/> Delete dependent(s) as of this day (mm/dd/yyyy)		Name(s)	
Are the dependent(s) being removed due to eligibility for - ➤ Healthy Montana Kids (formerly known as CHIP)? <input type="checkbox"/> Yes <input type="checkbox"/> No ➤ Healthy Montana Kids <i>Plus</i> (formerly known as Medicaid)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> Other (please explain)			
<input type="checkbox"/> Household Income Change – Indicate the applicable household income level below			
<b>HOUSEHOLD INCOME</b>			
List total household gross (before taxes) annual income from all sources, including: wages, Social Security or disability benefits, worker's compensation, distributions, unemployment, etc.			
<b>Single:</b> ___ Less than \$9,570 ___ \$9,571 – \$ 14,355 ___ \$14,356 – \$19,140 ___ \$19,141 – \$23,925 ___ \$23,926-\$28,710 ___ \$28,711 and over	<b>Married (no children):</b> ___ Less than \$12,830 ___ \$12,831 – \$ 19,245 ___ \$19,246 – \$25,660 ___ \$25,661 – \$32,075 ___ \$32,076 - \$38,490 ___ \$38,491 and over	<b>Single with children:</b> ___ Less than \$16,090 ___ \$16,091- \$24,135 ___ \$24,136- \$32,180 ___ \$32,181- \$40,225 ___ \$40,226- \$48,270 ___ \$48,271 and over	<b>Family (married with children):</b> ___ less than \$19,350 ___ \$19,351- \$29,025 ___ \$29,026- \$38,700 ___ \$38,701- \$48,375 ___ \$48,376- \$58,050 ___ \$58,051 and over
<b>CERTIFICATION AND SIGNATURE</b>			
<i>I certify, under penalty of law, that all my answers are correct and complete to the best of my knowledge. I understand the penalty for withholding or giving false information which may include a possible criminal offense (MCA 33-22-2009). I agree to provide documents to verify information on this form if requested. I understand that State staff may obtain documents and/or information to verify statements on this form. I also understand that I must report if my coverage ends within 30 days of the change. Any premium assistance payment I receive and am not entitled to will be required to be repaid to the Insure Montana program.</i>			
Signature			Date